Adult Mental Health Workgroup Minutes

Meeting #5
October 18, 2011, 10:00 am to 3:15 pm
Iowa State House, Room 22
Des Moines, IA

MINUTES

Attendance:

Workgroup Members: Deb Albrecht, Jerry Bartruff, Lynne Baltzer, Teresa Bomhoff, Becky Cleveland, Dr. Bhasker Dave, Lynn Ferrell, Dr. Michael Flaum, Chris Hoffman, Chuck Palmer, Patrick Schmitz, Kathy Stone, Christopher Atchison

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Jack Hatch, State Senator, Senate District 33, (Polk County), Co-chairs of the Legislative Interim Committee on MHDS Redesign. Joel Fry, State Representative, House District 95 (Clarke County)

Facilitator: Kevin Martone, Technical Assistance Collaborative (TAC)

DHS Staff: Theresa Armstrong, Nick Ford, Dennis Janssen, Laura Larkin

Other Attendees:

David Adelman	IAFP
Josh Bronsink	Senate Republicans
Amy Campbell	
Melissa Conley	Chatham Oaks, Iowa City
Vivian Davis	Chatham Oaks, Iowa City
Deb Dixon	Iowa Dept. of Inspections and Appeals
Sara Eide	Mercy Health Network
Bob Emley	Grand View University
Michelle Fiegl	Peer Connection
Kay Grotheo	AMOS MH/NAMI
John Hale	Iowa Caregivers Association
Kent Hartwig	Easter Seals/Brain Injury Association
Linda Hinton	ISAC
Todd Lange	Iowa Office of Consumer Affairs
Michael Maher	Counseling Associates

Liz O'Hara	University of Iowa-Center for Disabilities and Development
Brice Oakley	Iowa Alliance of Community Mental Health Centers
Joel Olah	Iowa Coalition on Mental Health and Aging
Kelley Pennington	Magellan Health
Jessica Perry	Hillcrest Family Services/Peer Support Training Academy
Johanna Pundt	Chatham Oaks
Jim Rixner	Siouxland Mental Health Center
Nicole Schultz	Iowa Pharmacy Association
Deb Eckerman Slack	Iowa State Association of Counties/County Case Management
Julie Smith	Iowa Health Systems
Amanda Stumpf	University of Iowa Health Care
Michelle Zuerlein	United States Psychiatric Rehabilitation Assn. (USPRA)

MEETING SUMMARY

Director Palmer provided updates on the Legislative Interim Committee and the process for submitting recommendations. On Monday Oct. 24, from 10 am-5pm, the Legislative Interim Committee will hold its first meeting at the Ola Babcock Miller Building (old Historical Building) on the 2nd floor. Steve Day, Kevin Martone and Valerie Bradley from the Technical Assistance Collaborative (TAC) will be there to discuss national efforts and how Iowa compares to other states regarding system development.

DHS will make available a list of recommendations that the workgroups have formulated, understanding that not each one will have 100% consensus.

The workgroup is going to review recommendations today and will also participate on a conference call on Thursday, Oct. 20, to continue reviewing recommendations to make sure workgroup's thoughts have been captured accurately.

The preliminary report is due Oct. 31 to the interim committee. TAC will formulate the report. The Department will formulate the final report due on December 9, 2011. DHS will honor the intent and work done by the workgroups and will work to integrate the work of the different workgroups, especially as related to common aspects of a regional system.

DHS will be discussing a strategy regarding the time frames in legislation for repeals of the system. There is consideration regarding phasing in of services, which services come in first and in which order. There is also work beginning regarding costing out of recommendations in the final report.

The second meeting of the legislative interim committee will be important. The committee will want information on where there is consensus so the legislative drafting process can begin.

Sen. Hatch complimented the workgroup and DHS on their efforts. He reviewed that the first meeting will be focused on financing and looking at other state's models. The second meeting on Nov. 17 will have workgroup recommendations presented and deliberated on. At the third meeting on Dec. 15, the plan is to have a clear legislative draft to share and then the committee will plan to meet as soon as the Legislature convenes in January to review it. It is still a very long process to get the recommendations through the legislative process. There will be plenty of time to continue to comment on the legislation. Both sides are working hard and working together to stay on track.

There will be public comment twice during the meeting today, one at 11:45 am and one at 3:00 pm.

Kevin Martone reviewed the co-occurring recommendations. Kevin participated in a conference call with Drs. Minkoff and Cline regarding the work on multi occurring/complex conditions. Drs. Minkoff and Cline have also sent a report on the work that has happened and is ongoing in Iowa. Kevin requested any workgroup comments on the Minkoff and Cline report.

- Positive feedback on the position statement in the report that no matter where someone goes, people should be recognized as complex individuals and there is a need to treat the whole person. Multi occurring is the exception not the rule.
- There was discussion on the training process regarding co-occurring for providers and technical assistance with agencies. Iowa Co-Occurring Recovery Network (I-CORN) is a group of people who are trying to get the state to recognize the need to change from bottom up as well as top down. The co-occurring training has been happening 4-5 years so how does the state build momentum to continue the process.
- The training has been with mental health providers, TCM, and recently ID and DD service providers; however, there are other providers who have also been working on separate co-occurring trainings and efforts. The training provided by Minkoff and Cline is one method among several. IDPH expects their providers to be co-occurring capable regardless of which model they are trained in.

In practice, does a consumer really feel welcomed by all providers and assuming they don't all feel welcomed, how does the state support that process improving? Are there are other recommendations that the group can make to strengthen this process? What is the state level implementation structure? Is there a multi agency group that addresses co-occurring issues?

- DHS and IDPH have tried to align their block grants more closely and stated in their applications that they would work with recommendations of the workgroup. IDPH is also providing incentives for providers who increase capability. Joint accreditation of substance providers and mental health providers is also on being considered.
- SAMHSA funded a co-occurring initiative about 10 years ago that involved multiple state agencies. This led to workgroups and regular meetings, what happened to that process?
- Could that be a recommendation from the workgroup to streamline standards for accreditation or licensure? Does the group recommend a separate process for reviewing multi-occurring issues or should it be built in to the system requirements?
- Providers need financial incentives to become more co-occurring capable as well as the "stick" of reviews to show that referrals and coordination happened.
- Concerned about separating out co-occurring when it should be embedded in everything we do. It's not a separate thing, it should be a routine. It should be inclusive of all conditions. If we over define it, it may become limiting.

The recommendation from Minkoff and Kline alludes to setting up a separate structure to ensure systemic implementation. How do you ensure from the state agency level that the change really happens at the client level given the resources available?

- Incentives are great but training reduces income of therapists. They have to see 6-8 people a day to keep the agency open and cover operating expenses. If scope widens it will be difficult to train the clinicians time-wise. It is difficult for mental health clinicians to get trained as CADC's.
- The co-occurring initiative is not necessarily about training. It seems that the initiative has been most useful in encouraging organizational review using the CCIC tools to discuss how agencies are doing regarding co-occurring capability. Once legislation is written we can review it for co-occurring language and processes in a structured way. It is recommended that agencies look at it more organizationally than as an individual training. This person doesn't think there needs to be separate co-occurring oversight, but there was a charter that the agencies signed in the past. For co-occurring, could there be a process similar to Olmstead across agencies?
- In a fee for service world, time is money. There is no time to plan or go to training. When clinicians are pushed to do too many things, agencies may lose experienced clinicians that they need.
- Director Palmer commented: If we go to a person-centered model or Systems of Care model, we are assuming co-occurring issues are evident and clinicians will be expected to be competent across disabilities. The question is how do you develop a competent workforce that is able to serve the complex client base?
- Clinicians would love more flexibility and ability to be creative with clients.
- The workgroup should be aware of co-occurring regarding physical as well as mental health issues. Providers should be able to recognize and support these issues also. This is not a training issue. It is the expectation, not the exception

that people have mutli-occurring conditions. It would be nice to have incentives but it's not necessary.

When the state is doing regulations, does the state have to do economic impact statements, environmental impact statements or some process that identifies the potential impact of the regulations? Similarly, could there be a requirement regarding review of impact of a regulation or rule on individuals with multi-occurring conditions?

- Does this normally occur now in the rules review process? Would this add another layer of review?
- Comment from Kevin: It appears the group does not support a whole new structure but what is the mechanism going to be to address this?
- There is a concern that it makes the state agencies look like they are checking up on each other.
- Kevin gave an example of the Dept. of Education promoting a rule that could affect individuals with co-occurring conditions. Does it consider the impact on people with multi-occurring conditions? How this would be addressed?
- Yes, agencies review each others' rules. Regarding promoting co-occurring capability, DHS has been committed to promoting this and IDPH has also. Do we need another external way to check up on this?
- Comment from Director Palmer: If we are going to the health home, person-centered SOC models, the expectation is to look at the whole person. Do we have the workforce that is able to work across multiple conditions? We may need to put in standards that define health home and systems of care. Within those standards, we will have competency standards.

- Is the question also about how much does it cost to get to this point?

Regarding regulations, co-occurring disorders can be missed in rulemaking. Are there sufficient cross checks to make sure that it is not missed? How do you make sure all agencies pay attention to this?

- From the clinician's point of view, how do you distinguish between different conditions? A person may have multiple mental health issues. We have to treat all the conditions, including those with mental health and substance use issues, mental health and intellectual disability issues, as well as those with medical issues in addition to those already listed. We have to treat the person as a whole. The question is should workforce receive specialized training? My agency strongly benefitted from the MInkoff and Cline training.
- The Director is on target with bringing in health homes. The current system is incentivized to see people as simple and not complicated. If a provider contacts other providers to collaborate and coordinate, that is on his own time. There needs to be a financial incentive to provide better outcomes, not individual treatment services.
- There are three levels of approaching this:
    1. Philosophically-legislative level
    2. How to bring it into actual practice-accreditation, certification etc.

3. Funding-what you get depends on who pays for it.

Final comments on multi-occurring/co-occurring disorders:

- We can leave in basic recommendations regarding workforce, accreditation etc.
- I like how the workgroup member identified the three levels of implementation and thinks the actual practice, level 2, will be the hardest to implement. Creating the evidence base will need to be addressed.

Workforce development recommendations:
Kevin asked for comments on workforce issues in the briefing paper presented at the last meeting.

- There is one thing missing. There are placement representatives/head hunters who could place practitioners in Iowa if their fees and salaries could be met. How do we focus on the financial aspect of getting providers here?
- Recruitment and retention are important, but we don't need five more psychiatrists, we need to use the ones we have more effectively. We use our professionals in inefficient ways. A study recently done says that Iowa may have enough psychiatrists if they are used differently. It is similar to the issue of how we use inpatient psychiatric beds. Having the psychiatrist see people every 15 minutes is not an efficient use of their skills.
- Regarding recruitment of professionals, what is the financial incentive to pay a headhunter and pay the provider a higher rate if the reimbursement system won't support it? Many providers have to contract with psychiatrists to get them in their facilities and at $150 to $200 an hour it's a loss service.
- Even if we use our psychiatrists appropriately, we still have a shortage of psychiatrists compared to other states. We are also behind in primary care physicians but it is not as discrepant as psychiatrists. We may have to look at incentives for psychiatrists in the short term. We are now training 8-10 psychiatrists at the University of Iowa. There used to be more locally trained psychiatrists. Another state has been recruiting Iowa psychiatrists with $150,000 signing bonuses.
- Yes, we have a shortage of psychiatrists, but also still have a bigger system problem that won't be solved by recruitment. We need new models to use psychiatrists more effectively. One that is similar to what is happening as a grant project for children, where primary care doctors can consult with the child psychiatrist, allowing the child to be served in the medical home.
- How many psychiatrists trained at U of I actually stay here, how can this be encouraged?
- The distribution of available psychiatrists across the state is not even. Most are clustered in a few counties. The psychiatric shortage map was shared. There may need to be incentives to encourage practice in rural areas.
- Comment from Rep. Schulte: The workforce shortage is also an issue related to the upcoming retirements of a significant number of psychiatrists. We need to look at scope of work issues soon. People other than psychiatrists may have to be allowed to do some of the work done by psychiatrists. We also need to

incentivize use of time for professionals we have to be more effective. We have to work with the people we have and incentivize for people who want to stay here.

- The scope of work issue regarding who can provide mental health commitment sign offs is being discussed in the court workgroup, especially in locations where there are no psychiatrists.
- It will take a multi-pronged approach. Recruitment, scope of work issues, mid level practitioners, redistribution of work, and telepsychiatry will all need to be a part of the conversation.
- Comment from Sen. Hatch: I am encouraged by this conversation and hope that it will lead to a description of how to ensure that the individual with highest need is seen by the highest level of practitioner. I think this can be made part of the medical and health home model and not just considered a workforce issue. Providers can be given incentives to work with this and allow changes in practice.
- It still gets back to who pays and how. If insurance and Medicaid still only pay for fee for service, then nothing changes. Private financing and insurance will have to be addressed also.
- Comment from Sen. Hatch: In the Affordable Care Act, private plans are required to include health homes in 2014. When it is reviewed by Supreme Court, the issue of whether it is mandatory for individuals to carry health insurance will be the debate, not the actual regulations.

The peer workforce is an untapped resource, how do we better utilize all providers? What is the strategy to address workforce issues? Who owns it? Who drives the strategy?

- Comment from Director Palmer: To some extent, the providers own it and CPC's own it also to some extent. Going forward, we would expect the regions to have expectations from the state to develop a service delivery system that meets certain standards. It is important to put in place some structure in the recommendations. All the recommendations mentioned need to be part of the final recommendations. The workforce issue is becoming a crisis, and there will need to be an ongoing structure to make sure plans are carried out, through the regional structure. If workforce issues are going to have traction, there will need to be legislative support similar to what the current redesign has had.
- I agree with most of what the director said. The critical piece is scope of work and reimbursement. It seems that would be more a state piece than a regional piece. The state will set those standards. This relates to co-occurring also.
- All those concepts come together. The health home is a method of organizing service delivery and the regions will be the vehicle for this.
- Comment from Kevin: Is the Director suggesting a group to look at this? The Director replied, yes, we will need a standing group with legislative and policy leaders that can move this forward that are focused on regions because they will be carrying out the State's plans. The region is a health home-multiple providers working together.
- The workforce report from several years ago has several good ideas.
- Nebraska funded a behavioral workforce collaborative two years ago.

- It is hoped that the regional group is keeping providers locations in mind when dividing state into regions. It wouldn't make sense for Linn and Johnson to be in the same region due to the large numbers of providers in those counties.
- Comment from Director Palmer: There are counties that are talking to each other and some that are not aligned. There are three clusters at different levels of development, but there has been nothing finalized on composition of regions.
- Kevin asked for comments on the peer workforce recommendations, related to training, certification and requirements for usage. Is there any structure to develop on this? Are there any concerns about peer workforce?
- There might need to be peer support for peer providers.
- We've utilized peer support in our agency, in both inpatient and outpatient settings. Some think it's going to solve the workforce issue, but there is a lot of burn out that should be addressed. They do a great job at helping people after discharge from hospitals, but not sure it will solve as many problems as is hoped.
- The wellness center in our area is staffed by peers only. It may be too much for one person to manage as it is high stress. The training process for peers may have some flaws. Many people have gone through the Iowa training, but only a few are interested in doing the work or able to do the work on a full time basis. Many are not well enough, so there may need to be a different process to decide who gets trained. Peer led support groups have been very helpful. It is less stressful for the peer leader, as it takes less time. We can't have peers replacing professionals.
- This all fits into the larger conversation of usage of workforce, and trying to fit them into the fee for service world.
- We still need to hear the peer voice regarding how they fit into the mental health system. We want to use their skills appropriately while respecting their own health issues.
- Comment from Kevin: Sometimes, if a peer counselor/employee leaves the job, it is perceived by some that the person wasn't ready for employment due to their illness when in fact it was the same burnout that traditional providers experience. Burnout needs to be addressed through supervision. The development of a peer workforce is not a solution to Iowa's workforce issues, but adds a new workforce tool into the system that is known to be effective.

There are a lot of peers who have a higher level of education. Are there barriers, such as rules and regulations, to having peers joining the workforce?

- In the substance abuse field, we have always had peers working in the field. What are the guidelines legally to recruit people with mental health issues if having lived experience is part of the job description?
- Comment from Kevin: Those positions are usually offered as requiring self-disclosure up front as part of eligibility for the job.
- We need to look at number of peer support specialists who are not working. What should the credentialing and training be? What are the costs for a peer to attend training? Some can't afford it.

- Salary and credentialing issues all should be considered. Some colleges collaborate on this and are also offering psychiatric rehabilitation training.
- In four reports the workgroup reviewed, one recommended centers for Iowa health workforce and one for clinical competency but this has not happened.

Kevin asked the workgroup to review the recommendations in the briefing document worked on last meeting. The recommendations are in the Briefing Document dated Oct. 18.

Workgroup Comments:

- On pg. 2, remove statement about documentation of a functional assessment in the clinical record and replace with functional status.
- Maybe use skills of daily living assessment for quick assessment.
- Change to assessment of functioning, separate from a formal functional assessment.
- On pg. 1, regarding "resident of state of Iowa," does this clarify status of undocumented individuals needing services?
- On pg. 6, committee to work on outcomes should include regional entities.
- On pg. 8, regarding phasing in of services, no county should be required to reduce current level of services to provide core services.
- It is a well written document and captures the information well.
- There is a concern about the focus on EBP's, and would like clarification on page 7. Would like more focus on sub acute as a step down service.
- In public comment, there has been a concern expressed about co-pay issues being a barrier for individuals and setting a co-pay for those above a certain income level. There may need to be a waiver of co-pay for some individuals. Regarding sliding fee scales, there is concern from peers about people being eased off of subsidies, not dumped from services when they start earning money.
- Kevin's comment: I thought there was consensus on co-pay and now it appears that there is not.
- Thought there was an upper limit above the poverty level percent for people to access services and also a way to ease people off as they work.
- Medicaid for Employed Persons with Disabilities is supposed to help address this. It has sliding fee scales and buy-ins.
- There will still be individuals who don't qualify for Medicaid, we have to address them.
- Which services will be subject to co-pay or sliding fee scale? The document refers to "particular service".
- Kevin's response: This wording came from statute.
- We might need a statement that the system should not disincentivize work.
- Regarding the previous public comment about not making the system worse than it is today, how do we make sure those individuals don't lose services?
- The current system is not at 250% of poverty level, only parts are. We will have to address equity.

- This is why if the level had been set at 200%, it would at least be equivalent with the substance abuse system.
- Kevin's comment: The past discussion was that if health care reform takes effect, there would be savings that could raise the income eligibility level.
- The workgroup had asked previously about data on how many people are served at the different levels of poverty.

Kevin stated there has been no further analysis since last meeting and we will have to either stay with the previous recommendation or not make one at all.

- The workgroup could stick with it, but with the recommendation to request an analysis of the income levels.
- Rep. Schulte stated she was not previously aware that counties had different financial eligibility guidelines. We do need equity, as counties get more funds based on a variety of different reasons as well as their tax levy rates. She recommends that the group stay with the recommendation as written, instead of not doing one at all.
- Suggested on page 7 to change the word "force". There is a question about who provides crisis evaluation when mobile crisis is not available. Suggestion to remove civil commitment language from the crisis residential section and just say inpatient. Not everyone gets committed who needs inpatient care. Regarding ACT on pg. 10, it must be financially viable if required.
- Be careful with requiring financial viability as ACT teams lose money in the first year and become budget neutral after that. Suggestion to add language about viability over time.
- Right now only Medicaid pays for it. What is the role of private insurance in paying for these types of services?
- Comment from Rep. Schulte: Most private plans are under federal oversight, state mandates affect only a small portion of private plans.
- We need to work with private industry on this as well.
- On pg, 1, residency, what is the definition? Is it already in code? Would like more clarification on what this means. Will it be used to limit services?
- Rep. Schulte responded that it will have to be redefined in Code. She also asked John Pollak from the Legislative Services Agency to comment on this. He stated that for voting purposes, residency is defined as the place where you sleep regularly.
- Rep. Schulte stated that residency would matter for the regions but we don't want it to be restrictive or set up as regions going against other regions regarding who will fund individuals.
- Comment from Director Palmer: The regional group has been working on this. We don't want to recreate legal settlement issues in regions. We still need to work through how people move from one region to another or receive services in one while a resident of another.

The group moved on to the section on Olmstead rebalancing issues pages.11-13:

Iowa has done well with usage of MHI beds. In other states, there has been more growth in forensic use of MHI beds. Iowa has stayed static in this. Most are civil admissions. Where does the group think funding should be focused?

Kevin brought up Olmstead issues, size of facilities, and the concern about recognizing RCF as a core service as being issues needing to be addressed. State hospital numbers are shrinking across the nation. There will probably be new regulations coming from CMS regarding the size of facilities. CMH may start funding only facilities of four people or less. The state of Georgia under its Olmstead agreement is prohibited from using more than four bed facilities. This affects how to think about serving people in smaller settings.

Workgroup comments:

- We don't want any MHIs closed until other places are available. There may be ways for MHIs to be more integrated into regional structure.
- Closing MHIs is not on the table. There is a gap in forensic inpatient services and MHIs could help. We are talking about RCF's. There are about 5,000 beds, most in Iowa are less than 16 beds. The Abbe Center in Cedar Rapids has made the decision to move people to smaller settings.
- Comment from Rep. Schulte: Abbe Center wants to move to smaller placements but is also under financial stress due to county budget issues.
- There is a statement in the document that outcomes are better in smaller facilities. Is this the idea that RCF's are smaller?
- Kevin stated that Iowa may continueto have facilities but the move should be toward smaller, more integrated settings.
- Director Palmer stated that it is confusing because RCF is so broad of a category and serve such a wide range of people. This makes it difficult to define or call a core service.
- The state cannot get reimbursement under Medicaid for RCFs greater than 16 beds under the 1915i waiver.
- What is the opinion of the Dept. of Corrections in regards to people coming out of corrections needing residential facilities?
- It is difficult for individuals in the correctional system to meet admission criteria for RCFs because of their criminal histories, specifically related to fire setting and sex offender issues.
- Are we looking at reclassifying types of RCFs to meet new system needs?
- Director Palmer stated that DIA has met with RCF industry to develop this and he feels they can identify a different category to serve those in need of step down services.
- In 2002 the MHIs lost 40% of beds, and had to initiate waiting lists. There have been shortages since then. Individuals sit in hospitals or U of I for 3-7 days. By the time they qualify, many are better and don't need it. The patient the MHIs receive is more ill and has not benefitted from short term hospitalization. They may exhibit destructive, dangerous behavior, require lots of manpower- frequently 1 to 1 care or more than one staff to one client. Since having to implement a waiting list, it is harder to get RCFs to take these individuals as the

RCFs can't send the client back to MHI if needed, because the bed is already full. Clients stay longer in the MHI as a result. Several examples were given of individuals with serious behavioral and medical issues that the MHI is currently caring for. There is a need for step-down or sub acute care for these really difficult patients to free up acute care beds but with the ability to support them if they need a higher level of care.

- Iowa only has 88 public acute care beds and we shouldn't reduce them.
- Comment from Kevin regarding forensic mental health and repurposing of mental health beds. If the workgroup believes its recommendations are going to work, the system is going to serve more people from the criminal system, who may need to be served in MHIs. The system will still send civilly committed individuals to hospitals but this will decline and beds may be repurposed for forensic patients.
- Is is true that MHIs could provide sub acute at a lower rate?
- Possibly, but it depends on the definition of sub acute. Acute care is $600-$700 per day so sub acute would be less but the cost is not known.
- There will need to be long term care for those with serious mental illness. There is a role for MHI but it shouldn't be as a regular acute care hospital. It should be used for the more specialized cases and services.
- Kevin commented that serving the person locally in his/her community would be better. How does the system reimburse for local acute care or support local acute care providers?
- Rep. Schulte commented that we need to get the people out who are stuck on the acute care units who aren't being paid for, before creating more beds. We need the sub acute to relieve the pressure on the acute care system.
- How can the regions create inpatient bed capacity when most people will be served by Medicaid?
- Kevin's response was that if person comes through who needs care but is uninsured, we want care to be available. We also want the service available for the Medicaid patient.
- Many patients are committed to MHIs under guise of needing long term care but are as acute as any other patient. Acute is viewed as short term, but many people are long term acute. The median length of stay is seven weeks.
- Kevin questioned who regulates hospitals acute care beds, and who would decide if beds can be opened?
- The issue is financial loss of the hospitals that have inpatient units, and the lack of available workforce. There is no incentive to increase beds.
- Comment from Rep. Schulte: Hospitals tried to do sub acute but it was not financially viable due to people being moved to lower level beds although still having higher needs. Physicians don't want to reopen those beds. There should be conversations about acute and sub acute at the same time.
- Comment from Director Palmer: We have to look at the definition of the types of beds. With the interim committee, the Department can bring together hospitals, DIA, etc to determine an adequate bed level strategy, and then put it out for comment.

- Substance Abuse residential units are providing sub acute now. We need to get a better picture of people leaving mental health settings who also have need substance abuse treatment.
- Comment from Rep. Schulte: We also need to define the need for forensic beds. The Dept. of Corrections needs to be at the table regarding this.
- The group needs to consider that the only forensic hospital in Iowa is inside a correctional facility (Oakdale). In this same hospital are also individuals under civil commitment, people found not guilty by reason of insanity (NGRI), and those ordered to have competency evaluations. Something to consider is moving the forensic hospital to the MHI system and out of the correctional system.
- It is also inside prisons where we are building mental health facilities, not in the community.
- Question from Kevin: Where are NGRIs sent? They are sent to Oakdale or can go to an MHI if found to be appropriate.
- The milieu in Oakdale is difficult because it is supposed to be an evaluation facility but has a mix of very difficult clients as well as people new to the system.
- Regarding acute care bed capacity, at least two recent inpatient closures were due to retirement of psychiatrists and none available to take over their duties.
- In addition to moving people to RCF from clinical settings, are we working on moving people from RCF to independent settings?
- Director Palmer commented that as facilities are more specialized and smaller, they are more likely to get bogged down.
- Kevin commented that for accreditation, certification and licensure issues DHS, IDPH and DIA all play roles. Many providers provide mental health and substance abuse services and have to go through two system's accreditation process. Is there a way to streamline this and reduce the burden on providers? The state should increase staff for accreditation if quality and safety are the desired outcome.
- Magellan does a thorough review of records. Could just Magellan be the quality reviewer? They do a good job at this and it would be consistent between the mental health and substance abuse providers. Providers say that their accreditation review may not go well, but the Magellan care review goes well. The two processes aren't always looking at the same elements.
- A provider has multiple reviews from IDPH, DHS and Magellan. Fewer reviews would be better. There was a start at coordinating between DHS and IDPH for joint reviews. Then both people involved retired.
- It is still on the IDPH list to do. IDPH has tried to coordinate more with DHS on the block grant. IDPH was directed to combine substance abuse and problem gambling several years ago. Deeming happens in this system, discussed cross deeming between IDPH and DHS.
- Rep. Schulte commented that accreditation/licensure should be specified to stay at state level.
- SF 525 legislation says standards should meet joint commission standards and there is a concern about the cost of this to the providers. The question is should this be required or not and what are the national standards?

- The language in SF 525 says “in conformity with”. It doesn’t require them to be Joint Commission accredited. There has been a cross walk of Joint Commission standards with Chapter 24 standards done before.
- IDPH has done this before with their standards to make sure they are complying with JCAHO.
- Comment from Kevin: Most states don’t require national certification, but many do accept it for deemed status purposes.
- Many services are not paid for by Magellan so they don’t review those records, such as supported community living. There does need to be more use of deemed status. There also need to be an update of standards and a better use of national accrediting bodies.
- Comment from Kevin: How does the state assure that an agency meets state standards other than those covered by national standards?
- Agencies have to submit documentation.
- Rep. Schulte stated that the SF-525 Chapter 230A section can be revised as it was included as written by the previous CMHC workgroup and changes may be needed.
- The issue of the CMHC as an organization was complicated when working on the crosswalk between DHS and IDPH.
- Kevin recommended a statement supporting work on accreditation streamlining between IDPH and DHS.
- Director Palmer added that work with DIA on function and standards of RCF and the different types and levels of beds should also be recommended.
- Would complaint investigation be combined as well?
- Currently it happens in both systems. IDPH goes before the state board of health.
- Director Palmer stated there is also work on an appeal process within the region.
- We should support joint accreditation across mental health and substance abuse as it comes back to building a co-occurring capable system.
- Magellan could do this for both systems with one visit.
- Director Palmer expressed support of this but said that it might need to be broader if we are going to the health home model.
- Kevin asked the group where prevention fits into this. Also, we want to encourage use of best practices in standards and current standards may not state that as strongly.
- We don’t want to reference specific practices in rule because they may be out of date later.
- Kevin replied that this is true but if regulations are on a review cycle then they should be reviewed and revised regularly.

Kevin stated that over the five meetings we have covered the topics we were required to cover by legislation. We will have revisions of this document to the group by Thursday, Oct. 20 for the phone call.

- There is no reference to suicide prevention activities and no reference to TCM in core services. Also there is no mention of school based services.

- Kevin commented that the role of schools is being addressed in the children's workgroup. There is a reference to combining TCM, case management and community support services in the document. It has not been decided yet what that should look like.
- IDPH did have a SAMHSA grant for youth suicide prevention which may come back. IDPH is trying to move it into other prevention activities and have more conversations with DHS about it.

Director Palmer thanked the group for their work. There will be additional work as the legislation moves through the process. There may be a need for further workgroups or some sort of collaborative process. Success will be measured by how the legislation moves through the legislature. It's going to take multiple types of resources to implement.

Rep. Schulte thanked the group. Many have been in these groups before and have said that it feels different this time, but there will need to be ongoing support to move the recommendations forward. The workgroup is requested to let the Legislature know what works and what doesn't as the system moves forward so it can be revised. Rep. Schulte also expressed appreciation for the public and consumer participation.

PUBLIC COMMENT

Comment: Supervision issues of peer support and non-peer support staff are the same in the workforce. There is concern about saying peers might be overstressed. There is concern about talking about a pyramid model of service delivery with the psychiatrist at the top, the patient should be there, not the psychiatrist. A barrier for peer support is money-agencies are not able to pay peers well. The CPRP certification is a good way for individuals to receive more education on mental health beyond Iowa Peer Support Training Academy (IPSTA). Peer support is one piece of the system.

Comment: The peer support training academy has heard concerns about how peers handle stress, but sometimes peers have better self-care plans in place than professionals. There also needs to be boundaries for peers who may also be clients of their employers. They work side by side with counselors and are expected to be professionals. Their lived experience can be very helpful. Regarding graduates of IPSTA, they are not all ready to be employed nor are all college graduates. There are also not enough peers to meet the demand currently.

Comment: Regarding workforce, please include recommendation on midlevel providers, the mental health center in Sioux City wouldn't function without them. Regarding co-occurring disorders, we all need to look at our own houses, medications may also need to be looked at. Private providers also need to be brought into the conversation.

Regarding the minutes of the previous meeting concerning the financial eligibility recommendation, Woodbury County is currently at 250% of poverty level. If it is lowered to 150% of poverty level, individuals will lose services. The workgroup is requested to please not do anything to make it worse than it is now. There is no evidence that co-pays encourage people to participate in treatment. We fund services to children through the county, which is not addressed in these groups. Let services continue that are helpful.

Comment: There is only one brief reference to transportation. There could be more emphasis on this in this workgroup or regionally. Also, after preliminary recommendations s are issued on Oct. 31, what will be the best way for the public to communicate their comments on it?

Kevin's Response: I will ask DHS and the legislative representatives about this.

Comment: We don't have a lot of time to consider workforce issues, but have a lot of good documents to review such as the workforce document from Oct. 4. This person focuses on the direct caregivers, a group that is in crisis as well as the larger workforce crisis issue. The direct caregivers are constantly in flux, it is not good for the consumers or the providers, as stable relationships are very important for consumers' success. It is requested that the group keep the direct care workforce in mind as the basis of the redesigned system.

Comment: Telehealth is in over 50 counties to help fill the gaps as well.

Comment: We need creativity to address workforce issues. IPSTA and the Magellan peer roundtable are both good. Peer support whole health and integrated health homes are also using peers as important team members.

Comment: A residential facility specializing in mental illness opened recently in Eastern Iowa and is already full. This facility is meeting a need currently not being met.

Comment: The Iowa Coalition on MH and Aging addresses the needs of older persons with mental health concerns. This is the fastest growing group in the state. There are also dementia issues to consider. They are working on implementing depression screening for the elder population. Please keep them in mind as recommendations are being formulated.

DHS Response: Dr. Kaskie provided good information about this. We need to make sure this is included in the recommendations. It can't be put off.

Comment: There is still concern about the document that appears to confuse actual services with models of care, specifically concerned about how psychosocial rehab, intensive psychiatric rehab, and clubhouse are classified.

Kevin's Response: The purpose of the document was to stimulate conversation about services. It is not the official list of core services. The group decided to go with domains and not specific services underneath the domains.

Comment: There is an Olmstead issue regarding increasing inpatient beds. Magellan has paid millions to keep people in beds past medical necessity due to lack of community alternatives. We need to focus on building community capacity.

Comment: We need a road map for further public comment on the final recommendations.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.